PERSONAL INJURY INTAKE FORM
(NON-AUTO ACCIDENT)

DATE OF ACCIDENT:_____

S.O.L.:_____

CLIENT INFORMATION:

Client's Name:_____

Client's Address:_____

_____

City: _____ State:_____ Zip Code:_____

County: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____

Work Phone: _____ Ext.:_____

Fax: _____ Work Days/Hours: _____

Client's SS#: _____ Client's D.O.B.: _____

INTERVIEW QUESTIONS:

1. **EVENT CAUSING INJURY:**

Date Of Injury: _____ Time of Accident: _____

Where: _____

_____

Objects: _____

_____

Owners: _____

Operators: _____

_____

_____

Others Present: _____

_____

What Happened: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Police: _____

_____

2. INSURANCE:

A. Health Carrier: _____

Address: _____

_____

Phone: _____

Insured Person: _____

Employer: _____

Contract No.: _____ Policy No.: _____

B. Auto Carrier: _____

Address: _____

_____

Phone: _____

Policy No.: _____

Named Insured: _____

Coverage & Limits: _____

C. Adverse Carrier: _____

Address: _____

_____

Phone: _____

Policy No.: _____

Adjuster: _____

Coverage & Limits: _____

3. EARLIEST LIMITATION DATE: _____

4. MARITAL STATUS: ___Married ___Separated ___Divorced ___Single

(*If Married or Separated, complete the following)*

Name of Spouse: _____

Date of Marriage: _____

Location of Marriage: _____

Spouse's Employer: _____

Address: _____

_____

Phone: _____ Fax: _____

5. CHILDREN:

Name	D.O.B
_____	_____
_____	_____
_____	_____
_____	_____

6. EMPLOYMENT:

Job Description: _____

Start Date: _____

Supervisor Name: _____

Pay: $_____

7. EDUCATION:

Highest Level Completed: _____

8. CONVICTIONS:

_____

_____

9. PRIOR CLAIMS:

_____

_____

10. MEDICAL:

Care during ten years before this injury: _____

_____

_____

Body parts injured in this event: _____

_____

Prior injuries: _____

_____

Care since this injury: _____

_____

_____

_____

_____

COMMENTS: